

Case Number:	CM13-0066284		
Date Assigned:	01/03/2014	Date of Injury:	06/03/2001
Decision Date:	04/26/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	12/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is an employee of [REDACTED] and has submitted a claim for carpal tunnel syndrome associated with an industrial injury date of June 3, 2001. Treatment to date has included acupuncture and medication. A utilization review from November 14, 2013 denied the request for Physical therapy 2 times a week times 4 weeks for the left bilateral wrists, left shoulder. Medical records from 2013 were reviewed showing the patient complaining of wrist pain. The progress note from October 11, 2013 is largely illegible. There were no other progress notes after the determination date. Previous physical therapy sessions were not mentioned.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Physical therapy 2 times a week times 4 weeks for the left bilateral wrists, left shoulder:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation CA MTUS, Shoulder Complaints, Wrist and Hand Complaints, Forearm, Wrist, & Hand Complaints

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: CA MTUS Chronic Pain Treatment Guidelines states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Guidelines support fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The guidelines support 8-10 visits over four weeks for neuralgia, neuritis, and unspecified radiculitis. The records indicate that the patient has wrist pain. However, the records do not clearly document specific functional deficits pertaining to the requested body parts (wrist and shoulder). There is no measure of functional deficit to establish the need to active therapy. Without evidence of specific deficits to be addressed, description of therapy intended, or evidence of a trial period, the request is not medically necessary.